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Immunization Update

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Meningococcal vaccine recommended for teens and college freshmen

New meningococcal conjugated vaccine (MCV4) licensed

The Advisory Committee on Immunization Practices (ACIP) to the Centers for Disease Control and Prevention (CDC) is now recommending routine vaccination of young adolescents with a newly licensed meningococcal conjugate vaccine (MCV4) at the pre-adolescent visit (11-12 year old). Introducing a recommendation for MCV4 vaccination in young adolescents (11-12 years old) may strengthen the role of the pre-adolescent visit and have a positive effect on vaccine coverage in adolescence. ACIP recommends that young adolescents see a healthcare provider at age 11-12 for a routine preventive visit, at which time appropriate immunizations and other preventive services should be provided. For those who have not previously received meningococcal vaccine, ACIP recommends vaccination before high school entry (~15 years old) as the most effective strategy towards reducing meningococcal disease incidence in adolescence and young adulthood. Within 3 years, the goal is routine vaccination with MCV4 of all adolescents beginning at 11 years of age. ACIP recognizes that vaccine supply may be an issue in the first few years after licensure of MCV4. Other adolescents who wish to decrease their risk of meningococcal disease may elect to receive vaccine.

College freshman who live in dormitories are at higher risk for meningococcal disease compared to other people of the same age. Because of the feasibility constraints in targeting freshmen in dormitories, colleges may elect to target their vaccination campaigns to all matriculating freshmen. The risk for meningococcal disease among non-freshmen college students is similar to that for the general population of similar age (18-24 years). However, the vaccines are safe and immunogenic and therefore can be provided to non-freshmen college students who want to reduce their risk for meningococcal disease.

Meningococcal disease is caused by bacteria that infect the bloodstream and the linings of the brain and spinal cord, causing serious illness. Every year in the United States, 1,400 to 2,800 people get meningococcal disease. Ten to 14 percent of people with meningococcal disease die, and 11-19 percent of survivors have permanent disabilities (such as mental retardation, hearing loss, and loss of limbs). The disease often begins with symptoms that can be mistaken for common

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Newsletter now available via email

In an effort to cut costs, the *Michigan Immunization Update* newsletter is now distributed via e-mail. Please consider switching to the email version, if you have not already done so. To be added to the electronic mailing list, simply send an e-mail message to franklinr@michigan.gov. Enter the word “Subscribe” in the subject field.

Those who are on the electronic mailing list receive this newsletter three times per year, in addition to the MDCH Fall Regional Immunization Conferences brochure, and periodic immunization information updates. As an added bonus, electronic subscribers receive the newsletter more promptly than subscribers who receive the newsletter through conventional mail.

The newsletters (both current and past issues) and the MDCH Fall Regional Immunization Conferences brochure are also posted on the Internet at http://www.michigan.gov/immunize.

For more information, you may contact Rosemary Franklin at franklinr@michigan.gov or 517-335-9485.

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illnesses, such as the flu. Meningococcal disease is particularly dangerous because it progresses rapidly and can kill within hours.

"Disease caused by meningococcal bacteria kills about 300 people each year in the United States. We are encouraged that today's ACIP recommendation will help to prevent this potentially deadly disease among adolescents" said Dr. Stephen Cochi, Acting Director of the National Immunization Program at CDC.

The vaccine is highly effective. However, it does not protect people against meningococcal disease caused by *type B* bacteria. This type of bacteria causes one-third of meningococcal cases. More than half of the cases among infants aged <1 year are caused by *type B*, for which no vaccine is available in the United States. The new meningococcal vaccine was licensed by the U.S. Food and Drug Administration (FDA) on January 14, 2005 for use in people 11-55 years of age. It is manufactured by Sanofi Pasteur and is marketed as Menactra™.

On May 27, 2005, the ACIP published recommendations for the use of meningococcal vaccines. *Prevention and Control of Meningococcal Disease: Recommendations of the ACIP* is available on the CDC website at www.cdc.gov/nip. The MCV4 vaccine can be administered to Medicaid eligible, uninsured, Native American and Alaskan Native children 11-18 years of age through the Vaccines for Children (VFC) program in private providers' offices. Private providers cannot vaccinate underinsured children (those whose health insurance does not cover immunizations) with publicly purchased MCV4 vaccine. Underinsured children should be referred to their local health department or federally qualified health center (FQHC) to receive MCV4.

Meningococcal fact sheet posted on CDC website

A new fact sheet on meningococcal disease and meningococcal vaccines is now available. This document seeks to familiarize vaccination providers, partners, and the public with the epidemiology and clinical features of meningococcal disease, with the new conjugate meningococcal vaccine (MCV4), and the previously licensed polysaccharide meningococcal vaccine (MPSV4). The new fact sheet is posted on CDC's website at www.cdc.gov/nip.

***A Quick Look at Using the Meningococcal Vaccines* is on page 15**

DECAVAC™ is licensed

Sanofi pasteur (formerly Aventis Pasteur) has released a new presentation of Td. At the same time, the company discontinued production of preservative-containing Td in 10-dose vials. The new Td presentation is called DECAVAC™ and is packaged in single dose, preservative-free Luer-Lok syringes (needles NOT included). DECAVAC™ will be offered in single-dose vials sometime this fall.

Managing vaccine inventories effectively

Is your vaccine still effective?

Vaccines that expire or are not maintained at the manufacturers' storage and handling recommendations may not adequately protect vaccine recipients. If improperly stored or expired vaccines are given to a patient, then the vaccines need to be re-administered or serology testing needs to be done to assure sufficient immune response.

With newly licensed vaccines soon entering the pipeline, immunization providers need to assure that vaccines are stored and handled properly. Providing potent vaccine to patients is a common desire among providers, but it's also a dollars and cents issue. After all, thousands of dollars worth of inventory may be stored in the refrigerator and freezer at any one time. If vaccine is not stored and handled correctly, the practice will have to spend money to replace their own privately purchased vaccine, in addition to reimbursing the State of Michigan for the loss of any Vaccines for Children (VFC) program vaccines. It is necessary to prevent temperatures from falling out of the appropriate ranges (35-46 degrees F or 2-8 degrees C in refrigerators; 5 degrees F or 15 degrees C or colder for freezers).

Ten simple steps can help avoid wasting vaccine:

1. Designate one person in the practice as the vaccine coordinator to monitor storage. Designate a back-up person to fill in when the vaccine coordinator is out. Train these people on proper storage and handling.

2. Record temperatures in both the refrigerator and freezer twice a day, preferably before the practice opens for the day and again at the close of the day. Keep the temperature log posted on the door of the unit. A back-up alarm system to monitor temperatures when the office is closed can be a lifesaver.

3. Thermometers should be in the center of both the refrigerator and freezer compartments to assure the most accurate reading. Make sure that the thermometers are calibrated accurately with a certified control thermometer.

4. Temperatures can fluctuate when the vaccine storage unit doors are opened frequently. Food storage is not recommended in the same unit as vaccine storage.

5. Don't store vaccines against the walls in refrigerators or freezers or in any shelving or compartments in the doors because the temperatures are not stable and can fluctuate.

6. Bottles of water in the refrigerator and ice packs in the freezer help to stabilize the temperature, reduce energy use, and give some protection from rising temperatures in a power outage situation.

7. Place vaccines of the same type together and rotate stock by always putting vaccines with earlier or shorter expiration dates in the front. Check stock every month and if any vaccine has expired, remove it. Aim for a 30-day supply of all vaccines.

8. Both the wall outlets and circuit breakers for the units should have "Do not Disconnect" signs prominently displayed. Maintenance personnel or others who don't know how important it is that vaccines be kept at stable temperatures might otherwise unplug the unit. Refrigerator and freezer maintenance should be done periodically.

9. Plug a clock into the same outlet as the vaccine storage unit and you will know when the power was lost. Then you have a good idea of how long vaccines were exposed to out-of-range temperatures in the case of a power outage.

10. Have an emergency plan in case of a power outage or vaccine storage unit failure.

If temperatures go out of range:

1. move all affected vaccines to a unit at the proper temperature,

2. call the vaccine manufacturer, and

3. VFC providers *only:* call the local health department

In some cases where the temperature range isn't extreme or out-of-range for too long, vaccine can be salvaged and the practice will not have to purchase replacement vaccine or repay the VFC program for wasted vaccine. It is important to note that the manufacturer will determine whether or not vaccine is salvageable.

MCIR provides information about adolescents as well as younger children

The Michigan Childhood Immunization Registry (MCIR) is a computerized database that contains immunization records of all children in Michigan. Even though MCIR was not fully functional until 1998, it contains a large amount of immunization information on adolescents.

Trends in the number of children in MCIR are quite similar to trends in the number of children born in Michigan, as Chart 1 shows. For the past 10 years, there have actually been more children in MCIR than were born in Michigan; this is partly due to people moving into the state. Children born since 1994 have also had their birth certificate data loaded into MCIR. However, MCIR still contains records for most children born before 1994.

Many of these older children and adolescents also have immunizations recorded in MCIR, as is shown in Chart 2. In fact, half of all children in MCIR born in 1985 had 10 or more immunizations recorded in MCIR.

One of MCIR's many benefits includes its ability to help prevent the

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Chart 1. Number of children recorded in MCIR and number of live births in Michigan, by year of birth

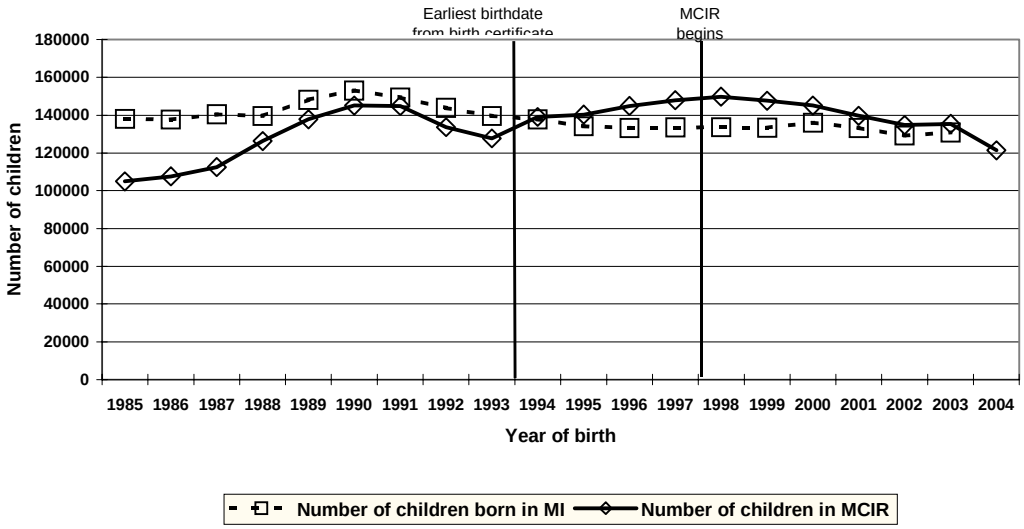
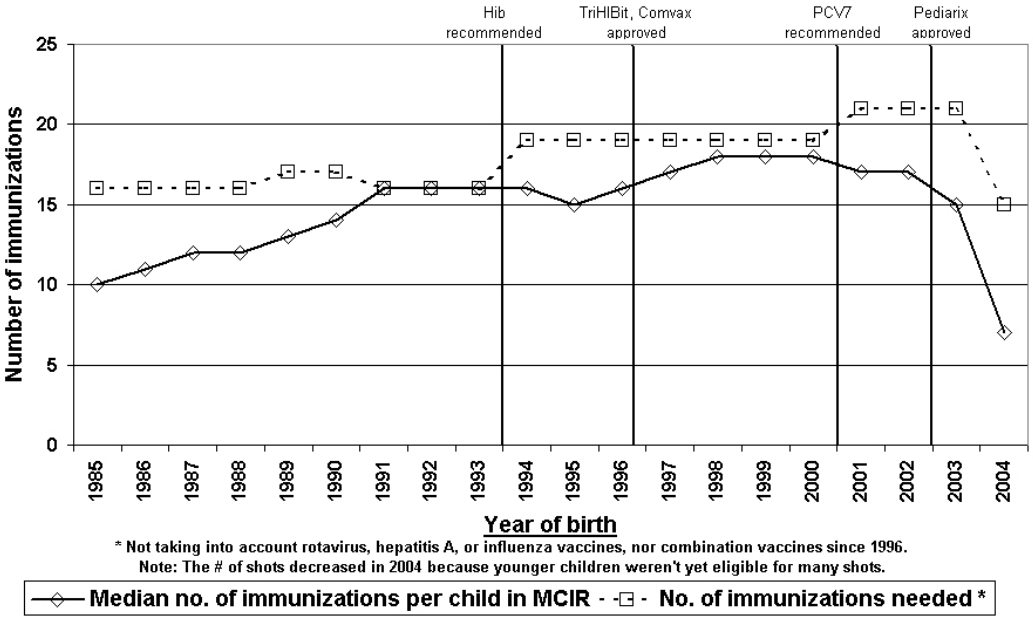


Chart 2. Median number of immunizations per child in MCIR & approx. number of immunizations needed*, by birth year



* Not taking into account rotavirus, hepatitis A, or influenza vaccines, nor combination vaccines since 1996.
Note: The # of shots decreased in 2004 because younger children weren't yet eligible for many shots.

MCIR provides information

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administration of unnecessary vaccines. This can be achieved by taking the time to check on all patients' immunization records in MCIR before administering vaccines. By checking all patients – adolescents as well as younger children – providers will be able to do a better job of avoiding giving children unnecessary vaccinations. They will also save time and money.

As an extra bonus, patients and parents will be happy to avoid the unnecessary shots. Providers are therefore encouraged to use MCIR for adolescent patients, as well as for young children

MCIR's usefulness will continue to improve as health care providers enter immunization records for older and younger children alike.

www.MCIR.org just had a facelift!

Find information for providers, schools, parents, HMOs and more.

Be sure to visit www.MCIR.org today, and check out its new look!

CDC and NIH responds to Simonsen et al flu study

A statement by the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH)

A study published in February 2005 in the *Archives of Internal Medicine* reported that vaccination of the elderly population against influenza may be less effective in preventing death among the elderly than previously assumed. This study's findings have caused some confusion about whether people 65 years old and older should receive an influenza vaccination.

CDC and NIH continue to support the Advisory Committee on Immunization Practices (ACIP) recommendation that people aged 65 and older get vaccinated against influenza each year. People aged 65 and older are at highest risk for complications, hospitalizations, and deaths from influenza. Vaccination remains the best protection from influenza available for people 65 and older and their loved ones.

Numerous studies have shown that influenza vaccination works – including to help protect the elderly from serious illness and hospitalizations – but the degree to which it works varies from year to year and can be difficult to measure. For example, influenza seasons differ each year in length and severity, and the health status of individuals also matters.

In the current study by Simonsen et al titled "Impact of Influenza Vaccination on Seasonal Mortality in the U.S. Elderly Population," the authors in no way imply that the elderly should not receive influenza vaccine. Rather, the study concludes that the vaccine may prevent fewer deaths among the elderly than previous studies would have suggested. Therefore, the authors note that there is room for improvement in influenza prevention efforts, including research into developing more effective vaccines for the elderly and the increased use of medicines to treat flu.

In addition, recently published studies raise the possibility that it may be beneficial to vaccinate larger numbers of healthy persons, including children, to prevent transmission of influenza viruses to high-risk persons such as the elderly.

Expansion of groups for whom influenza vaccination is recommended is under discussion by the ACIP and CDC, and is partly contingent on adequate vaccine supply in the future.

CDC and ACIP continually review their influenza vaccine recommendations as well as studies and published research in order to develop the best recommendations for protecting all Americans from influenza. This study is a reminder that there is room for improvement in how we protect the elderly from influenza, and CDC and NIH encourage research that strengthens our ability to do so.

The director's corner

By Gary Kirk, MD, MPH, Director, MDCH Division of Immunization

By the time you read this column, the 2004-2005 influenza season will be over. However, considerable work in planning for subsequent seasons remains to be done. Much of this work revolves around advance planning, as we try to avoid many of the difficulties imposed by this last flu season's vaccine shortage.

The vaccine shortage started when Chiron announced on October 5, 2004, that none of its flu vaccine would be shipped to the U.S. (due to contamination), leaving the U.S. about 50 percent short of its desired vaccine allocation. CDC quickly established priority groups, intending that the public and private sectors vaccinate individuals at greatest risk of developing the flu and suffering from its complications. On October 14, Michigan took the additional step of creating a public health order to ensure that vaccine was reserved for those within the priority groups.

In a major breakthrough, sanofi pasteur (formerly Aventis Pasteur and the sole remaining major manufacturer of flu vaccine for the U.S.) shared flu vaccine distribution data with CDC, allowing states (and counties) to see where vaccine had gone in their jurisdictions. Ultimately, the sharing of data led to a secure CDC-based ordering system for end-users to get additional vaccine.

By December 9, Michigan had rescinded its public health order, encouraging all citizens wishing to avoid the flu to get vaccine. This was prompted by data demonstrating a decreased demand for vaccine despite an ample supply. There was also evidence that some of the State's most vulnerable citizens were well covered by vaccine (e.g., those living in nursing care facilities).

In mid-January, 2005, CDC made three announcements to encourage the use of the remaining stock of flu vaccine: 1) In states which judged their vaccine supply to be ample, CDC encouraged the vaccination of all individuals wishing to avoid the flu, 2) CDC made their Vaccines for Children (VFC) program vaccine a federal asset and allowed transfer of this asset to states, granting the use of VFC vaccine in non-VFC individuals in public and not-for-profit settings, and 3) CDC allowed sanofi pasteur to "borrow" flu vaccine from the national stockpile to market and sell it to any end-user.

As I write this column in early February, none of us can say with certainty whether, in this year of great vaccine shortage, all available flu vaccine will be used. What we can say, however, is that this flu season has been a rocky one and has exposed a number of opportunities for the private and public sector to work together more harmoniously on a number of different levels, including the state level.

It should be noted that we were fortunate to have many dedicated private and public individuals and organizations involved in the response to this year's vaccine shortage. In no particular order, the Michigan Health and Hospital Association, the Michigan Osteopathic Association, the Michigan Nurses Association, the Michigan State Medical Society, the Michigan Association for Local Public Health, the Michigan Association of Public Health and Preventive Medicine Physicians, Visiting Nurse Associations/Services across the State, the Michigan Association of Health Plans, Blue Cross Blue Shield of Michigan, the Michigan Advisory Committee on Immunization and others all provided invaluable input and assistance this season.

Despite all the wonderful help, however, we learned that we need to have better plans in place to communicate, distribute vaccine, and coordinate roles and activities more effectively and efficiently in the future. Some states have well-established flu advisory committees, comprised of public and private members, to do their planning; other states have *ad hoc* groups that convene to accomplish similar goals. By the time you read this, approximately seventy private and public sector representatives (from the groups listed above and MDCH) will have attended a March 15 Influenza Vaccine Shortage Meeting to address the planning issues. I am hopeful great things will come out of this initial meeting. Please stay tuned.

Get up-to-date information quickly

To be added to the immunization mailing list, simply send an e-mail message to franklinr@michigan.gov. Enter the word "Subscribe" in the subject field.

Those who are on the electronic mailing list receive this newsletter three times per year, in addition to the MDCH Fall Regional Immunization Conferences brochure, and immunization information updates, which are issued on an as-needed basis.

Please note that it if you have already signed up for the immunization listserv, it is NOT necessary to send us your email address again.

Influenza Update: 2004 – 2005

The Michigan Department of Community Health (MDCH) influenza surveillance group meets weekly during flu season to review data compiled by the Divisions of Communicable Disease and Immunization in the Bureau of Epidemiology, and by the Virology Section of the Bureau of Laboratories. The sources of these data include individual and aggregate reports of influenza and influenza-like illness collected in the Michigan Disease Surveillance System (MDSS), MDCH laboratory-confirmed cases, sentinel laboratory reports, sentinel physician reports, and reported outbreaks. Syndromic surveillance data include emergency department visits for constitutional and respiratory chief complaints in addition to sales of selected over-the-counter medications. Taken together, these data provide a broad picture of influenza activity in the state and are used to monitor the timing and impact of disease due to influenza activity and characteristics of circulating viruses.

In Michigan, surveillance indicators started to show mild increases in influenza-like illness activity in mid-December 2004, but marked increases were not evident until the last week of January 2005. Influenza activity appeared to peak in mid-February and had returned to low levels by mid-March.

Laboratory surveillance revealed co-circulation of influenza A and influenza B viruses, particularly after January. All the influenza A viruses cultured by the MDCH laboratory were of the H3N2 subtype; further antigenic characterization of a subset of these isolates at the Centers for Disease Control and Prevention (CDC) revealed that both A/Wyoming/3/2003-like and A/California/7/2004-like viruses were circulating in Michigan. A/Wyoming matches the A/Fujian component of the 2004-2005 trivalent vaccine but A/California, a drift variant of A/Fujian, is not a complete match. The influenza B viruses that were isolated belonged to two antigenically and genetically distinct lineages. Most were B/Shanghai/361/2002-like viruses, related to the vaccine strain. Some of the B isolates, however, were B/Hong Kong/330/2001-like and were not related to vaccine strain.

The highly pathogenic avian influenza A H5N1 epizootic resurfaced in Asia this season and was accompanied by sporadic reporting of cases in humans and other mammals. One instance of probable person-to-person spread was reported in the *New England Journal of Medicine*[1], reminding us of the importance of a strong surveillance system as we prepare for a future influenza pandemic. If your clinical practice would like to join this effort by participating in the Michigan influenza sentinel provider surveillance network, please contact Rachel Potter, Vaccine-Preventable Disease Epidemiologist, at 517-335-9710 or potterr1@michigan.gov.

1 Ungchusak K, Auewarakul, P, Dowell SF et al. Probable person-to-person transmission of avian influenza A (H5N1). New England Journal of Medicine (2005); 352(4): 333-340.

Sentinel physicians are needed

The Michigan Department of Community Health (MDCH) is looking for physicians to participate in the Centers for Disease Control and Prevention (CDC) Influenza Sentinel Provider Surveillance Network. Starting in October and continuing year-round, sentinel physicians will report weekly counts of visits due to influenza-like illness in four age categories and total patient visits by fax or Internet to a central data repository at the CDC. They will also collect about 11 nasal swabs from a sample of patients with influenza-like illness for virus culture at no charge by the MDCH laboratory. Most participating physicians report that this activity takes less than 30 minutes per week. Physicians in any specialty that provide primary care are eligible, including family practice, internal medicine, pediatrics, infectious disease, OB/GYN, and emergency medicine. Surveillance can be conducted in a variety of sites including private provider's offices, emergency rooms, urgent care centers, college / university student heath centers, and health maintenance organizations.

Sentinel physicians monitor the impact of influenza activity in the outpatient setting. On a larger scale, sentinel reports may provide advance warning of an emerging influenza pandemic. Given Michigan's status as an international border state, this vigilance takes on even greater importance. For these reasons, MDCH urges Michigan physicians to volunteer for this program. If you are interested in participating or would like additional information, please call or email Rachel Potter, MDCH Vaccine Preventable Disease Epidemiologist, at 517-335-9710 or PotterR1@michigan.gov.

Physician Peer Education Project updates health care providers on immunizations

The Physician Peer Education Project on Immunization (PPEPI) brings free immunization education to health care providers across Michigan in an effort to raise Michigan's immunization rates and improve immunization practices. The educational modules are delivered in a one-hour format covering topics such as pediatric, adolescent, family medicine, adult, obstetric/gynecology and influenza immunization. The modules are brought to providers at grand rounds, medical staff meetings, conferences and their local offices.

The program is delivered through one of seventeen seasoned physicians who actively teach and promote the use of immunizations. PPEPI reaches more than 1,500 providers each year through over 50 education sessions.

The program is administered through Michigan State University Extension. If you would like to schedule a session, contact Tammy Sullivan at (517) 432-8204.

Gary Johnson, MD, MPH, Medical Director, Genesee County Health Department, provides a pediatric immunization update to family practice residents at McLaren Regional Medical Center.

Charles Barone II, MD, Chair, Department of Pediatrics at Henry Ford Medical Group, gives a pediatric immunization update to physician assistant students at Wayne State University.

MDCH is an Equal Opportunity Employer, Services and Programs Provider

The following free programs are available upon request

Physician Update – contact Tammy Sullivan at 517-432-8204

Immunization record assessment – contact Stephanie Sanchez at 517-335-9011

Office Staff Update – contact Carlene Lockwood at 517-335-9070

Hepatitis A-E – contact Pat Fineis at 800-964-4487 or 517-335-9443

How one physician is making a difference in Tuscola County

Tuscola County Health Department (TCHD) has had an active Immunization Coalition for about eight years. Since its inception, there has been one key person who has committed himself to regularly attending these immunization coalition meetings. His name is Parikshit Kumar, M.D., and he is a pediatrician with Caro Family Physicians. Dr. Kumar provides immunizations in both his Caro and Vassar offices. Caro Family Physicians uses the Michigan Childhood Immunization Registry (MCIR) and is the recipient of the MCIR Region 4, Award for Excellence in 2004.

In order to receive the Award for Excellence, practices must meet certain criteria. Caro Family Physicians received this award because they:

- provide vaccines through the Vaccines for Children (VFC) program
- access MCIR through the web
- submit immunization information on a regular basis
- submit historical records of children born after January 1, 1994

In addition to the above criteria, the fact that this is a multi-provider office was also taken into consideration.

In January 2005, the Michigan Department of Community Health (MDCH) AFIX team conducted an AFIX assessment of the 19-36 month olds for 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 hep B and 1 dose of varicella vaccine. The AFIX findings revealed that Caro Family Physicians has the

Dr. Kumar and his staff are committed to protecting their patients against vaccine-preventable diseases.

majority of the single vaccine coverage levels greater than 90 percent, with the exception of the fourth dose of DTaP at 81 percent, which is still much higher than average.

Dr. Kumar and his staff are committed to protecting their patients against vaccine-preventable diseases and work collaboratively with the TCHD in immunization education, promotion and accessibility for the community.

The AFIX program

AFIX is a quality improvement strategy to raise immunization coverage levels and improve standards of practices at the provider level. The acronym for this four-part dynamic strategy stands for: **A**ssessment of immunization coverage of public and private providers, **F**eedback of diagnostic information to improve service delivery, **I**ncentives to recognize and reward improved performance, and e**X**change of information among providers. For more information about AFIX, call Stephanie Sanchez at 517-335-9011.

Immunization Update 2005 course is July 28

The CDC's *Immunization Update 2005* satellite course is scheduled Thursday, July 28, 2005. This live satellite broadcast and webcast will provide up-to-date information on the rapidly changing field of immunization. Anticipated topics include new recommendations for influenza vaccine and an update of the influenza vaccine supply, meningococcal conjugate vaccine, acellular pertussis vaccine for adolescents, and revised varicella vaccine recommendations. The 2.5-hour broadcast will occur live on July 28th from 9:00 am to 11:30 am and will be re-broadcast that day from 12:00 noon to 2:30 pm. Both broadcasts will feature a live question-and-answer session in which participants nationwide can interact with the course instructors via toll-free telephone lines. The program will also be available as a live webcast which can be accessed through the internet. More information is available at http://www.phppo.cdc.gov/phtn

Put your practice or clinic in this newsletter

The *Michigan Immunization Update* staff would like to include more articles that feature local programs, practices, or events. Would you consider contributing an article about your practice? We would love to hear from you. For more information, contact Rosemary Franklin at 517-335-9485 or franklinr@michigan.gov.

Mercy Family Care uses MCIR to improve immunization rates

Contributed by Sharon Polek, Region 5 MCIR Coordinator

Mercy Family Care, located in Grayling, has been working hard to improve the immunization rates for their 19-35 month-old patients. The practice has approximately 100-120 patients in the 19-35 month age range at any one time. In 2004, Mercy Family Care's immunization rate for this age group was 63 percent.

The Mercy Family Care staff realized that in order to improve the immunization rates, changes needed to be made. Deanna Garrity, Office Manager, led the effort to improve the rates. Using the Michigan Childhood Immunization Registry (MCIR), the office sent reminders to parents when immunizations were due. The office staff also made notations in patients' charts of upcoming immunizations that were due. In addition, the office asked the local health department's immunization nurse educators to give updates to the staff.

These efforts have paid off. One year after implementing these practices, 92 percent of the 19-35 month-olds within this practice are up-to-date on their immunizations, as measured by MCIR. Sue Lucksted, RN, PHN, from District Health Department 10 said, "They have proved that dedication to their patients and to the vaccine program pays big dividends for all."

The Mercy Family Care staff proved that dedication to their patients and to the vaccine program pays big dividends for all.

Questions & Answers

Q Are we supposed to keep single-dose vials of vaccines in the refrigerator that have been partially used? The staff in my office was instructed by one of our physicians to save these vials, and then use the leftover vaccine for other patients. Can this be done?

A No. Single-dose vials or syringes generally contain preservative-free vaccine. (One exception would be preservative-containing flu vaccine.) This means that once the vial is opened (and no longer sterile due to the introduction of the needle/air particles) there is nothing to stop bacteria from growing in this vial. Potentially you would be injecting the next person with something that could cause an infection. All multi-dose vials contain a preservative to prevent this from happening.

AIM Provider Tool Kit order form is on pages 13-14

Change coming for varicella reporting

The Michigan Department of Community Health (MDCH) will be recommending a change in reporting procedure for varicella cases (also known as chickenpox) with the start of the 2005-06 school year.

Currently, surveillance for varicella involves aggregate case-count reporting. Physicians, schools, and child day care centers report simple case counts of the numbers of cases for certain age groups to local health departments (LHDs) on a weekly basis. These counts are tallied for each age group and in turn sent from the LHDs to MDCH weekly.

The new change will require varicella cases to be reported on an individual, named-case basis, similar to the way other notifiable diseases are reported. This change, which is being implemented nationwide, was initially a recommendation of the Council of State and Territorial Epidemiologists (CSTE) and subsequently endorsed by the Centers for Disease Control and Prevention (CDC).

Varicella vaccination has been a part of the routine childhood immunization schedule for nearly ten years. Since then, varicella immunization coverage rates have increased impressively and chickenpox levels have declined substantially (in Michigan, the annual incidence of varicella has dropped over 80 percent compared to ten years ago). A national varicella surveillance system has become feasible.

As has occurred with other vaccine-preventable diseases, such as measles and rubella, the success of the varicella vaccination program may be changing the epidemiology of the disease in other ways. Modifying varicella surveillance to a case-based reporting approach will allow improved monitoring of varicella epidemiology with respect to such variables as time, place, and age, among others. Ultimately it will yield a better understanding of the impact of immunization on the disease, and may provide data for further policy development guiding varicella vaccine use and practice, for example whether a second dose is needed for optimal protection.

Despite the tremendous drop in chickenpox disease levels, CDC acknowledges that levels may still be too high for in-depth case investigation and extensive data collection. Therefore, case reporting and data collection likely will focus initially on just three variables (in addition to basic case demographic information): age, varicella vaccination history, and a simple index of the case's severity of illness. In time, as incidence declines further, additional information will be required.

Again, this change is not scheduled to begin until the start of the 2005-06 school year. At this time local health departments and their disease-reporting partners (schools, day care centers, health care providers) are encouraged to begin thinking about and planning for this modification of chickenpox reporting**.** Additional information and guidance will be made available in coming months.

Number of reported cases of vaccine preventable diseases, Michigan, 2005

(Year-to-date as of May 31)

Disease	Total cases, year-to-date
Chickenpox (varicella)	2,117
Diphtheria	0
H. influenzae b invasive disease	0
Hepatitis B	70
Measles	0
Mumps	12
Pertussis	90
Polio	0
Rubella	1
Tetanus	1

New and revised Vaccine Information Statements (VIS) are available

Japanese Encephalitis

CDC published a new VIS for Japanese Encephalitis in May. We now have VIS for all licensed vaccines (except BCG, for which we probably won't do one).

Influenza

VIS for both TIV and LAIV are in draft and should soon be available (no date yet). Note that, because influenza is being added to the Vaccine Injury Compensation Program this year, new editions will have to be published. These will take time to develop, and they might not be ready by the start of flu season. The most recent version (dated 5/24/04) is available from MDCH.

Hepatitis A

Hepatitis A was added to the compensation program in December. A new VIS is going through the development process. Until it is published, continue using the current VIS dated 8/4/04.

Meningococcal

Like influenza, meningococcal vaccine is expected to be added to the compensation program. For now, an "interim" version (dated 4/4/05) is available from MDCH. It is considered "interim" because it was made available before the ACIP published its recommendations on the new conjugate vaccine. Once these recommendations are published, the VIS will change.

Tdap

There will be a VIS for the newly licensed Tdap vaccines. No prediction yet on when it will be available. But as soon as it is, MDCH will distribute it to local health departments. In the meantime, health care providers using the vaccine can use the package insert, or any other available materials, as a basis for informing parents or patients about the vaccine's risks and benefits.

Td

The new Td VIS is on hold until we determine how Td recommendations will blend with those for Tdap. Keep using the current one (dated 6/10/94) for now.

How to get Vaccine Information Statements

VIS are available from your local health department. In Michigan, it is important to use the Michigan versions of VIS because they include information about the Michigan Childhood Immunization Registry (MCIR). By state law in Michigan, parents must be informed about MCIR. VIS that are obtained from other sources (e.g., from the CDC or IAC websites) do not contain information about MCIR.

Foreign language versions of VIS (which include information about MCIR) are available in 32 languages. To receive VIS in foreign languages, call the Michigan Department of Community Health at 517-335-8159.

VAERS has a new website address

The Vaccine Adverse Event Reporting System (VAERS), a passive surveillance system that monitors vaccine safety, was established in 1990. VAERS provides for close monitoring of the incidence of adverse events, adequate scientific evaluation of possible associations, and appropriate response to newly identified risks of vaccine. In short, this system ensures that vaccines are as safe as possible.

The VAERS website address has been changed to http://www.vaers.hhs.gov. Please note that CDC is still distributing VAERS materials that list the old address; however, users that access the old website, http://www.vaers.org, will be redirected automatically to the new site. CDC and FDA will incorporate the new URL into documents over time. The VAERS mailing address (P.O.Box 1100, Rockville, MD 20849-1100) and toll free number (800-822-7967) will not change.

VAERS

www.vaers.hhs.gov

Free immunization brochures and materials order form

Order these materials online at http://www.hpclearinghouse.org

If you prefer, you may fax this order form to (517) 699-2376. For information about orders that have already been placed, call the MDCH Clearinghouse toll-free at (888) 76-SHOTS. Any other questions should be directed to Rosemary Franklin at (517) 335-9485 or franklinr@michigan.gov.

Please enter quantity for each requested item. (Orders for brochures are usually limited to 500, unless otherwise stated. Limits on orders may be temporarily decreased if inventory is low.)

Quantity needed	Item requested
(Limit 1 per office)	**Alliance for Immunization in Michigan (AIM) Provider Tool Kit, 2005** This packet contains up-to-date information for health care professionals who administer vaccines to their patients, including updated immunization schedules for children and adults, information about contraindications, administration, documentation, and storage and handling of vaccines.
(Limit 1,000 cards per office)	**Adult Immunization Record Card**
(Limit 50 cards per office)	**Influenza Vaccination Pocket Guide –** (the pocket guides are for health care providers ONLY)
(Limit 50 cards per office)	**Pneumococcal Polysaccharide (PPV23) Vaccination Pocket Guide –** (for health care providers)
Quantity needed	**Brochures**
	Keep Your Family Safe from the Flu
	If you have diabetes, getting a flu shot is a family affair
	Immunize Your Little Michigander
	Shots for your child (about the Vaccines for Children program)
	Are you 11-19 years old? Then you need to be protected…
	Vaccine Safety – What parents need to know

Quantity needed	Brochures
	Adult Immunizations – Are you protected?
	Hepatitis B: What Parents Need to Know (With special information for pregnant women)
	The Dangers of Hepatitis B: What they are, How to avoid them
	Hepatitis, What you need to know (ABCs)
	Antibiotics: What You Should Know
	What is West Nile Virus?

Fax this form to the MDCH Clearinghouse at (517) 699-2376

Name: _____

Type of clinic/practice: ❑ Pediatric ❑ Family Practice ❑ Adult/Internal Med ❑ OB/GYN ❑ Specialty

Email address*: _____

Street address:** _____

City: _____ **State: MI**** **Zip code:** _____

Phone no.: (include area code) _____

*** Complete email address to receive immunization information updates.**

** Reminder: We cannot ship to P.O. boxes. ** Materials are available to Michigan residents only.

For more information or special requests, contact Rosemary Franklin at (517) 335-9485 or franklinr@michigan.gov

Revised June 17, 2005

A Quick Look at Using the Meningococcal Vaccines…..

Meningococcal Conjugate Vaccine (MCV4)
Meningococcal Polysaccharide Vaccine (MPSV4)

Meningococcal Vaccines	**MCV4** (conjugate)	MPSV4 (polysaccharide)
Brand Name	Menactra™	Menomune®
Serotypes included	A, C, Y, W-135 (no serogroup B)	A, C, Y, W-135 (no serogroup B)
Age for Use	11-55 years	2 yrs and older
Schedule	One dose (no revaccination)	One dose (**may** need revaccination 3-5 yr
Route of Administration	**IM** (Intramuscular)	SC (Subcutaneous)

Who Should Get Meningococcal Vaccines?

· Children 11-12 years old at preadolescent visit (6th grade)
· Adolescents entering high school (about age 15 yrs)
· College freshman, living in dormitories
· Any adolescent desiring to reduce their risk of disease
· Persons with a damaged or removed spleen
· Persons with HIV
· Persons with terminal complement component deficiency
· Persons traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa
· Persons who might have been exposed to meningitis during an outbreak (except serogroup B outbreaks--not in the vaccine)
· Military recruits Lab personnel working with these organisms

Vaccine For Children (VFC) Program

· **MCV4** can be administered to Medicaid eligible, uninsured, Native American, and Alaskan Native children 11-18 years of age through the VFC program in private providers' offices.
· Under-insured children 11-18 years of age can receive **MCV4** at their local health department (LHD), federally qualified health center, or at a rural health clinic.
· Contact your LHD for information on recommended age groups and vaccine availability.

Points to Consider

· **MCV4:**
  - Preferred vaccine for persons 11-55 years of age
  - Expected to give better, longer-lasting protection
· MPSV4:
  - Should NOT be routinely administered to adolescents
  - Should be used for children 2-10 yrs old and adults over 55 yrs
  - May be used for persons 11-55 yrs if **MCV4** is not available
· Revaccination:
  - No current recommendation for revaccination after one dose of **MCV4**
  - For persons who remain at high risk for disease 3-5 years after 1st dose of MPSV4, a single revaccination dose may be given (Use **MCV4**, if available and person is 11-55 yrs)
· Vaccine Information Statement (VIS) "Meningococcal Vaccines"
  - Same VIS used for **MCV4** and MPSV4

Administration Tips/ Storage and Handling

· **MCV4:**
  - Given intramuscular—**IM** only
  - Causes a local reaction like Td- give Td and **MCV4** in different sites
  - Comes in a single dose vial, ready to draw into a syringe
· MPSV4:
  - Given subcutaneous—SC only
  - Must be reconstituted- use the diluent provided by the manufacturer
  - Administer all of the reconstituted vaccine
· **MCV4** or MPSV4 can be given simultaneously with other vaccines
· **MCV4** and MPSV4 are stored in refrigerator at 35º-46º F (2º-8º C)

Documentation

· Document by type of vaccine (**MCV4** or MPSV4) on the:
  - Vaccine administration record in the patient's chart
  - Green (child) or yellow (adult) vaccine record card
· Document in MCIR:
  - **MCV4** as "meningococcal conjugate" (CPT 90734)
  - MPSV4 as "meningococcal polysaccharide" (CPT 90733)

Prevention and Control of Meningococcal Disease, Recommendations of the ACIP, CDC MMWR May 27, 2005 www.cdc.gov/nip

Rev. 6/24/2005

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Hepatitis C conference will be held in October

The Michigan Department of Community Health, in conjunction with the American Liver Foundation – Michigan Chapter, is planning a statewide conference on hepatitis C. *Hepatitis C: Collaboratively Confronting the Challenge* will be held on October 27, 2005, at the Marriott Eagle Crest Conference Center in Ypsilanti.

Mark Sulkowski, M.D., Associate Professor of Medicine at Johns Hopkins University School of Medicine and the Medical Director of the Viral Hepatitis Center, will start the conference with a keynote address focusing on the natural history and epidemiology of hepatitis C.

A plenary session focusing on social, cultural, political, and economic barriers to effectively addressing this epidemic will follow the keynote. The plenary, to be given by Laurie Showalter, Viral Hepatitis Program Manager for the National Alliance for State and Territorial AIDS Directors (NASTAD), will emphasize the need for advocacy to overcome these barriers.

The final plenary of the day, to be given by Dr. John Ward, Director of the Division of Viral Hepatitis at the Centers for Disease Control and Prevention, will be a call to action. Through this presentation, participants will be asked to consider the future through discussion around the question "Where do we go from here?"

In addition, 18 workshops, in the following 6 workshop tracks will be held: 1) prevention, 2) diagnosis/ management/treatment, 3) injection drug use/substance abuse, 4) HIV/ HCV co-infection, 5) special populations, and 6) action and advocacy.

The conference is designed to meet the needs of a diverse group of health care and health and human service professionals.

For more information about the conference and/or continuing education credits or to be put on the mailing list for registration brochures contact Lori Stegmier, Viral Hepatitis Planning Coordinator at 616-456-0457 or 517-335-9435.